University of Alberta

This is to certify that the undersigned have read and recommended to the Committee on Graduate Studies for acceptance a thesis submitted by Gilbert M. Campbell, B.A., M. D., entitled, "Insecurity and Psychosomatic Symptomatology"

Insecurity and Psychosomatic Symptomatology

Gilbert M. Campbell, B.A.,M.D.
(Alberta)

Department of Philosophy

A thesis submitted to the School of Graduate Studies in partial fulfilment of requirements for the Master of Arts degree.

University of Alberta

April 1947

ACKNOWLEDGMENTS.

The writer wishes to take this opportunity of thanking Dr. A.F. Anderson, Superintendent of the Royal Alexandra Hospital, Mrs. Eric Richardson, Medical Social Worker, and Dr. S. Spanner for the use of their files. In addition, the writer is deeply grateful to Dr. D. E. Smith of the Department of Philosophy for the constructive criticism which he has offered throughout this work, and to those friends whose interest and helpful suggestions have made each stage of this study less arduous.

TABLE OF CONTENTS

CHAPTER I.

CONSIDERATION OF MIND-BODY QUESTION

CHAPTER I.

Psychosomatic Medicine is a recent medical philosophy which has been evolved, not as a conscious attempt at solving the age-old problem of the relationship existing between the mind and the body, but rather as a practical approach to Medicine. However, the mind-body question, per se, has existed in philosophical and psychological thinking since the time of Plato. Whether the psychosomatic approach to medicine will prove to be an ultimate solution is a matter of conjecture although empirically it appears to be of value and would seem to be, for the time being at least, the most comprehensive and rational approach to medical problems. However, the basic tenets of this newer medical mode of thought are not entirely speculative as considerable material has been brought forward in both the fields of Biology and Psychology in support of the psychosomatic ideology.

Throughout the centuries, in attempting to solve the mind-body problem, three general methods of solution have been evolved. These three methods are termed the Monistic, the Dualistic and the Organismic

or Double-Aspect, theories. As Psychosomatic Medicine is based on the organismic approach to the question only a brief survey of the other two theories will be made.

Those thinkers who have propounded a monistic solution explain all human behaviour by discounting either mind or body (matter). Men such as Berkley and Kant have evolved a philosophy in which they claim that the only reality is the mind and its ideas. Such monism does away with all material substance and the belief is that what we consider to be material substance exists only through our minds and the ideas we have of these material bodies. Another form of Monism is that in which mind is not considered essential in any explanation of human behaviour. This method of reasoning became most fully developed in the theories put forward by followers of the Behaviorist school of psychology. All activites of animals and man alike are explained on a basis of physiological processes and any consideration of mind is believed to be superfluous.

The protagonists of Dualistic theories

recognize both mind and body. However, even they are not entirely in agreement and the methods of explanation which they propound are divisible into two main categories: Interactionism, and Psycho-physical parallelism. The Interactionists recognize both mind and body and feel that at some point these two aspects of man come together and react on each other. Descartes, for example, believed that the point of interaction was in the Pineal Gland. The Psycho-physical Parallelists, on the other hand, while recognizing both mind and body, insist that they are two separate and independent aspects of the human organism. This approach to the mind-body question has been made the basis of the theories of such men as Bain, Hartley, Leibnitz, Spinoza and Wundt.

A method of psychology which does not fall specifically into the two forms of dualism is that of the Dynamic School of Psychology. The teachings of William McDougall (1) exemplify this mode of thought. He recognizes both mind and body as such but is, however, not concerned as to whether they are two separate and self-contained entities. In his psychology he uses them both in the explanation of the facts found

in psychological observation. He is primarily concerned with goal-seeking drives as the means of determining the behaviour of man. Mental energy can be converted into physical energy and he is little concerned as to the nature of this energy.

The Organismal point of view, as accepted by Psychosomatic Medicine, is one which feels that the organism, human or otherwise, cannot be regarded a being made up of either mind or body, or as a sum of individual parts but rather that it must be considered as a functioning integrated totality. A. Meyer (2) in approaching the problem expressed this attitude by saying "What is of importance to us is the activity and behaviour of the total organism or individual as opposed to the activity of single detachable organs. It is more than cerebration." He further enlarges on this idea in his definition of psychobiology: "Psychobiology as thus conceived forms clearly and simply the missing chapter of ordinary physiology and pathology, the chapter dealing with functions of the total person and not merely of detachable parts."

The work of Coghill, the neuroanatomist, is perhaps the greatest contribution in the experimental field toward a solving of the relation of psyche to soma and the organism to environment. His main interest lay in the study of the development of the nervous system. Of particular note is his work on the Salamander, Amblystoma, which he considers to be comparable to the higher vertebrates in its developmental mechanism of integration (3). From his work he finds evidence against the idea of reflex-chains and organismal unity as a result of the association of discrete parts. These ideas are of course fundamental in the teachings of the Behaviorists. As evidence against these ideas he writes: "The neural mechanism, while effecting integration in the older muscles, is growing into the younger, non-functional muscles, so that when the latter becomes sensitive to neural excitation they are in perfect integration with the total functioning system." He points out that the motions of various parts of the body do not arise as a series of reflexes which become integrated into the whole but rather that they are at all times a part of the total organismic

pattern and arise as a result of differentiation. He says that the order of growth is a "progressive individualism within a totally integrated matrix, and not a preogressive integration of primarily individuated units."

He is convinced that as a result of his studies all behaviour can be explained on a scientific basis and does not require any hypothetical or vitalistic conception. He is lead to the conclusion that "Insofar as the correlation of nervous structure and function in the development of the individual has been carried, structural provision has been found for the perpetuation of spontaneity, autonomy, or initiative as a factor in its behaviour. Any theory of motivation, therefore, that attributes this function wholly to the environment, is grossly inadequate." Although Coghill did not work himself on human embryos he is of the opinion that his findings in Amblystoma are equally applicable in the case of man.

Later Coghill discusses the subject of instincts and reflexes in bahaviour (4). Reflexes he says, arise as the result of firstly an inhibition

of the total pattern of activity and secondly as individuation of certain activities of a part of the organism. These more independent activities are, however, still normally subordinate to the total organismal activity. As Dunbar (5) points out in her discussion of Coghill's work: "Instincts, which are 'total action patterns in response to relatively general situations' are more primitive than reflexes. The vestibular connections develop before the vestibular sense organs: this means that the cerebral growth determines the attitude of the individual to its environment before that individual is able to receive any sensory impression of its environment. Hence the initiative is within the organism."

Coghill also refers to a subject of interest to Physiologist and Psychologist alike. He says (6) "The mechanism of the total pattern is, accordingly, a growing organ; and from the first it grows in an expanding embryonic neural matrix from which new elements grow progressively into it. This, according to my conception, is the organ of so-called instinctive behaviour. But in the nervous matrix, particularly

in the cerebral cortex, the most embryonic part of the brain, in which this organ of the total pattern grows, there is a constant tendency toward individuation, which tendency is the organic basis of partial patterns of all ranks, from local reflexes to multiple personalities....Normal behaviour requires that the total pattern maintain sovereignty over all partial patterns; but through decadence of the organ of the total pattern, or hypertrophy of mechanisms of partial patterns, that sovereignty may give way to the dominance of parts that are normally its subjects, and, as a result of this, behaviour may cease to serve the individual as a whole appropriately; that is to say, it may cease to be normal."

K.S. Lashley (7) in his work "Basis Neural Mechanisms in Behaviour" brings out some further pertinent points. In his discussion he points out the inadequacy of the idea of cerebral localization and reflex pathways. By means of extirpation techniques in his investigation of rats he found that the rate of learning was not a matter of the function of individual cells but rather of the total mass of tissue.

It would appear from this that cerebral functional units are "modes of organization" and "the cortex seems to provide a sort of generalized framework into which single reactions conform spontaneously, as the words fall into the grammatical form of a language."

In the field of Psychology the idea of organismal unity has also appeared. This concept is of particular importance in the teachings of the Gestalt school. The very use of the word Gestalt itself is significant for, as Heidbreder (8) points out, the Gestalt "is a whole that is not merely the sum of its parts. It is primary to the parts and fundamental to them." Their whole approach to the subject of psychology shows an emphasis on the idea of the "whole". For example, sensation is the perceiving of the total pattern not the realization of individual sensations which form the whole.

The Organismal point of view is also gaining an ever increasing popularity in the field of clinical medicine. Ill-health is coming to be understood as a disturbance of vital equilibrium. Dunbar (9) in referring to the work of H. Marx points out "The fact that man in health lives in a sense of organismal

integrity, somatic and psychic processes being firmly enmeshed, forming a harmonious structure which is health itself. In illness, however, a disturbance of this harmonious structure may occur, somatic and psychic processes becoming separated so that their interaction becomes literally a counteraction, an antagonistic action. Disturbance of somato-psychic integrity can be the determinant of a disease, may be even disease itself."

W. A. White (10) considers that the mind should be considered in the light of evolution even as has been done with the body. He points this out when he states: "In fact the mind is conceived to be but a particular kind of reaction of the organism - a reaction of the organism as a whole, a total reaction...." And again: "What has happened is that the knowledge of the mind-body phenomena has increased enormously, both analytically and synthetically. While analytically they are much more clearly differentiated than ever before, still synthetically, they are seen but to be different aspects of the same integrated whole."

Freud and other followers of Psychoanalysis are considered by some to be thoroughly monistic in their outlook. However, it is not so much that they are monistic as that they have directed most of their efforts toward the investigation of the mechanism of the Psyche rather than the psychosomatic relationships. Actually the Psychoanalysts in their work are somewhat of a liason between the field of pure science, so-called, and that aspect of psychology which has been developed by the clinicians(11). Freud was originally a Biologist and hence in his work he is fundamentally biological. He claims that all psychic events are the result of the conflict of instinctive biological drives or wishes that are incompatible. D. Feignebaum (12) in discussing the Psychoanalysts writes: "Psychoanalytic observations ever and again enforce the regognition that both physical and mental phenomena are forms of expression of a single collective vitality, such that the foreground is occupied, indeed, now by the one mode of expression, the mental, now by the other, the physical. Present-day bio-psychology must assume an uninterrupted interactivity

of the two systems as an established fact."

In concluding this chapter it would perhaps be advisable to mention the subject of Emotions as this topic is actually the basis of all psychosomatic thinking. Several theories of Emotion have been brought forth. The psychosomatic practitioner is, of course, not too keenly concerned with such theories as long as he feels he is able to cope with emotional factors when they appear in the patient. However Hulsey Cason (13) has developed a theory of emotion which is not only in keeping with organismal theories but also to some extent is an explanation of the variations in emotion in the same and different individuals. He says "The theory which we wish to propose is that feelings and emotions are organic patterns of interacting activities which simultaneously involve many different kinds of processes, although the different processes may not be involved to the same degree. In addition to conscious experiences and associated language habits, the affectivities always simultaneously involve processes that are physical, chemical, neurological, endocrinological,

visceral, sensory, muscular, conscious, unconscious, etc.; and the causal factors operate in both directions between each activity and practically all of the other activities involved in the total organic pattern. The sensory processes, for example, influence the nervous processes and the nervous processes influence the sensory, the nervous activities influence the muscular and the muscular influence the nervous, glandular processes influence the nervous, verbal activities influence the visceral, autonomic functions influence the muscles, and conscious and unconscious mechanisms have a mutual influence on each other.....

The interacting-pattern theory seems to afford the only satisfactory explanation of individual differences in affectivity. According to the present view, the affective differences between different people and in the same person at different times are due to differences in the organic pattern of interacting activities, and the differences between different feelings and emotions in the same person are also due to differences in the organic pattern of interacting activities. In all individuals, some organic patterns disappear and do not return, and

these affectivities are never present again. Other interacting patterns appear for the first time when maturity is approached, and this is the reason some emotions are not experienced at an early age. Individual differences in the organic patterns of interacting activities and individual differences in affectivities coincide exactly with each other."

BIBLIOGRAPHY

(1) Wm. McDougall. The Energies of Men. 1932.

(2) A. Meyer. Objective psychology or psychobiology with subordination of the medically useless contrast of mental and physical. J.A.M.A. 65. 1915, 860-862; disc. 862-863.

(3) Coghill. Correlated anatomical and physiological studies of the growth of the nervous system of Amphibia. In: J. Comp. Neurol.

The mechanism of integration in Amblystoma punctatum.

(4) Coghill (through Dunbar). The structural basis of the integration of behaviour. Proc. Nat. Acad. Sc. 16, 1930, 637-643.

(5) Dunbar. Emotions and Bodily Changes. 1938, 14.

(6) Coghill (through Dunbar). The biologic basis of conflict in behaviour. Psychoanalyt. Rev.20, 1933, 1-4.

(7) K. S. Lashley. Basic neural mechanisms in behaviour. Psychol. Rev. 37, 1930, 1-24.

(8) Heidbreder. Seven Psychologies. 1933, 331.

(9) Dunbar. Emotions and Bodily Changes. 1938, 39.

(10) W. M.White (through Dunbar). The narrowing of the gap between the functional and the organic. Am. J. Psychiat. 7, 1927-28, 221-229.

(11) F. Dunbar - Emotions and Bodily Changes 1938, 30.

(12) D. Feigenbaum (through Dunbar) - Experimentelle Beitrage zur Dynamik und Oekonomie des Triebkonflikts. Imago 12, 1926, 147-170.

(13) H. Cason - The interacting -Pattern Theory of the Affectivities. Psychol. Rev. 40: 1933, 287.

CHAPTER II.

A SHORT SURVEY
of the
BASIC IDEAS OF PSYCHOSOMATIC MEDICINE

CHAPTER II *

The approach to the patient as a total personality is not a new one. Medical men in all ages have known that the emotional life of the patient played an important part in his illness. However, with the advent of Virchow's discoveries in the study of tissue pathology, the stress became placed more and more on the somatic aspects of man, and illness began to be explained in terms of cellular disease. With the increasing development of this approach, medicine became mechanized, and diagnosis was made on the basis of electrocardiography, basil metabolic findings and other laboratory diagnostic methods. The findings by means of these laboratory techniques were of tremendous importance, but it was unfortunate that the emotional aspects of the patient's life were frequently neglected. However, more recently there has been a gradual reformulation of values,

---

* The greater part of the material on the background and fundamental concepts basic to the practice of Psychosomatic Medicine has been drawn from the book, "Psychosomatic Medicine", by Weiss and English. This book is the most recent and comprehensive study in this particular field of medicine now available.

and once again the emotional factors in the life of the patient are becoming recognized as important in the diagnosis of illness.

Unfortunately, the organic tradition has become so thoroughly entrenched in the thinking of the medical man that many find it difficult to accept certain illnesses as arising from purely emotional considerations. Even while admitting the power of emotion in illness, they still feel there must be some physical basis for all disease. This attitude is even more apparent when there is actual organic pathology present, but when there is also a large emotional componant. In such cases, the organic is considered to be sufficient in explaining the symptoms. This is termed by the psychosomatists, the "either -or" concept in medicine. On the other hand, the practitioners of Psychosomatic Medicine adopt the attitude that the age of the "either - or" outlook is past. They are convinced that illness will in the future be considered not as emotional or physical, but rather as to how much of one, and how much of the other, is playing a part in the

causation of the illness. They felt that, whereas in the past diagnosis of emotional factors has been done by a process of exclusion, the future examination of the patient will include a personality study of the patient, as well as the physical and laboratory examinations.

The interest of the psychosomatic practitioner is, of course, directed toward all illness. However, there are certain groups which command his greatest interest. These particular illnesses may be grouped into three general categories. The first of these divisions is concerned with those people who, though not "out of their mind", have no definite bodily disease to account for their illness. These are the individuals with the so-called "functional diseases". The second group is comprised of cases in which, although there is organic pathology present, there is also a large emotional factor as well. These are of particular interest from the psychosomatic point of view, as it is felt that the emotional factor is capable of doing considerably more damage here than in the former cases. An example of this situa-

tion is found in the diseased heart, where the presence of emotional factors may add seriously to the work of the already damaged heart, and may hasten a more rapid breakdown of that organ. The third category is made up of those diseases considered to be wholly physical, yet having to do with the 'vegetative nervous system". Such conditions include migraine, asthma and essential hypertension. The great interest in these illnesses is aroused by the fact that emotional factors may play a large part in their etiology and also in their management.

These latter illnesses touch on another problem which is becoming of increasing medical interest - the possibility of a relationship between psychological disturbances and structural alteration. It has been recognized more recently that functional impairment may lead to cellular disease. The belief is now being entertained that psychological disturbance may antedate functional impairment.

In referring to the nature of emotional problems in disease, and what measures may be taken to meet them, a quotation will be made from Weiss

and English (1) which expresses clearly the tenets of psychosomatic practitioners. "First of all let us say that these patients are suffering from disturbances in their emotional lives; that is, the illness is wholly or in part of psychological origin and can be satisfactorily studied and treated only if this factor is adequately dealt with. It is true that the ill-health may arise from long standing dissatisfactions in the business, social or home life of the individual and that this failure of adjustment to environment is manifested by a disturbance in some part of the personality, either as b bodily symptoms of various kinds, capable of mimicking almost any disease, or as affections of the spirit resulting in attacks of anxiety, obsessions, phobias, depression and other disturbances of mood. What is not so generally realized is that the mere discovery of the so-called dissatisfactions or unpleasant occurrences in the life situation of the individual is not a sufficient explanation nor even an adequate indication of the psychic background of the illness. In other words, besides excluding

physical disease in the one case and correctly evaluating the part it plays in another, it is of the greatest importance to know the patient's ability to adjust to certain life situations, his pattern of reacting to them, the degree of anxiety in his make-up and the nature and seriousness of his conflicts....."

In making a psychosomatic study of the patient, the approach is that of considering the patient as a total personality rather than as an exclusively medical case. Besides a knowledge of his physical condition, information should be gained concerning his personality, and his family and social background. To satisfy both the physician and the patient, a thorough medical history must be taken. Then a complete physical and laboratory examination is made, to exclude physical disease or decide on the degree present and to estimate the amount of disability which should result from organic pathology.

Once the medical man has made a diagnosis,

he then tactfully informs the patient either that there is no organic pathology to account for the symptoms, or else that the symptoms present are out of proportion to the amount of physical disease. He then attempts to show the patient how emotional factors are capable of producing physical manifestations, and uses such easily understood examples as blushing, goose-flesh and diarrhoea to illustrate his point. By this means he may enable the patient to understand that his symptoms are due to a disturbance in his emotional life. The next step is to persuade the patient to talk about himself as a person. Naturally, the individual is most anxious to talk about the symptoms which have caused him to seek medical aid. However, by astutely guiding the conversation the doctor should be able to lead the patient into a discussion of his personal affairs, and by this means the therapist may come into possession of the real problem which is disturbing the individual.

One method used to help the patient in understanding his symptoms is the use of 'organ

language'. Organ language is an empirical concept which has arisen in psychosomatic studies. In many cases it has been discovered that certain personality types when reacting to emotion-producing situations manifest symptomatology in similar organs of the body. Also it has been found that the organ of choice is often symbolic of the form of emotional conflict occurring in the particular personality pattern of the patient. The individual suffering from chronic constipation is considered to be the personality type in which 'giving' is difficult. The other extreme is found in those people who are inclined to 'give until it hurts'. These are the so-called 'colitis personalities'. By use of the idea of organ language, the patient may be made to realize that his symptoms of nausea and vomiting may be due to some situation in his life which he is unable 'to stomach'. His urticaria or some other dermatological condition may be caused by someone or something 'getting under his skin'. Examples of organ language are many, and are easily understood

by the patient, as such symbolism is frequently used in everyday language. An explanation of the cause of his organic symptomatology is given to the individual. Because he is suffering from emotional conflicts and tensions, these tensions must be realized. If he is unable to relieve them by means of words or action, the body expresses the need for release of tension by means of its organs.

Psychosomatists also feel that apart from aiding the patient in understanding his condition, organ language is also of help in diagnosis. Organic symptomatology is believed to be a method of behaviour, and as such is considered to be important in gaining insight into the needs of the patient.

Another concept which the practitioners of psychosomatic medicine hold is that of symptomatic conditioning. They frequently find that people who develop certain psychosomatic manifestations may have been exposed to symptoms of a similar nature in someone else. It is not unusual to find that a patient presenting cardiac symptoms has at some time been in close relationship with someone who has suffered from,

and may have died as a result of , cardiac disease. This can apply to any organ of the body. If such conditioning is present, it is of the utmost importance to discover the source, in order that the patient may be shown its relationship to his own condition.

Now a final word on psychotherapy in Psychosomatic Medicine. An integral part of the psychotherapeutic procedure is the taking of the patient's initial emotional history. The very fact of his being able to discuss his emotional problems gives him a considerable sense of release. This is, of course, the ancient idea of catharsis. By realizing that his symptoms are mainly emotional in origin, the patient is often reassured to a considerable degree. This is particularly true when the patient is shown that we are all, at some time or other, subject to psychosomatic symptoms of a greater or lesser degree, and such manifestations are not shameful. However, for real psychotherapy , the patient must be made to understand the meaning

of his symptoms and the nature of his conflicts. There is a course of re-education, and during the process of emotional maturation the need for symptom formation may be abolished.

Not all patients, unfortunately, respond to psychotherapy. Especially is this found to be the case in those patients who have presented psychosomatic symptoms for such a great period of time that their illness has become part of their pattern of life. It may be the only possible way in which they are able to experience even a modicum of emotional adjustment, and in many cases it is felt that if the physical symptoms were removed, the result could easily be a mental breakdown of a serious nature.

BIBLIOGRAPHY

(1) Weiss & English - Psychosomatic Medicine
1943, 8 .

CHAPTER III

BASIC NEEDS FOR EMOTIONAL MATURATION OF THE INDIVIDUAL

CHAPTER III.

Emotional growth, and the needs for its normal maturation, has been studied by psychologists with varying methods of approach. On the one hand Freud and his followers have considered all emotional responses, whether adequate or inadequate, to be the result of an innate unitary drive which sets the individual in his course of action. This drive demands certain requirements for its satisfaction and the degree to which they are met determines the emotional maturity or immaturity of the individual. On the other hand psychologists such as McDougall interpret human behaviour in the light of a number of goal-seeking drives. These drives have certain demands for the realization of their wants and emotional problems arise as the result of the conflict of these innate drives or from the non-satisfaction of their needs.

In a consideration of these ideas it is impossible to determine if either interpretation of

human emotional behaviour is adequate. Certainly, however, there appear to be a number of environmental requirements which are essential in the development of an emotionally mature individual. Whether they are to be interpreted in the light of a single or multiple drives is of little concern to the modern clinical psychologist or medical practitioner. They are interested mainly in those factors in the environment which by their presence or absence have been found to help develop a normal emotional stability in the individual. Thus in most recent books on clinical psychology a somewhat similar picture of the fundamental needs of the individual is presented even though there may be a variation in the approach to the individual problems.

The material for this chapter has been drawn from Levine's book "Psychotherapy in Medical Practice". The book is a modern text which has been written essentially for the general practitioner but the ideas he sets forth in regard to the emotional needs of the individual are in accord with psychosomatic

studies and those of other psychologists interested in this aspect of human behaviour. In this chapter which deals more specifically with this problem, Levine refers particularly to children but much of the material is applicable to adult needs as well. It is now commonly recognized, of course, that the personality of the adult and his ability to adjust to the varying conditions of day to day living are the product of the degree to which his emotional needs have been met in childhood. Levine also presents his case in terms of what he considers to be the necessary attitudes of the parent to the child but the same ideas can as easily be adapted to the point of view of the child himself.

The first need of the child is a sense of security in the parent-child relationship. He should feel that he is not alone in the world and that he can turn to his parents and the family in time of trouble. In the human there is a long period of absolute and comparative dependency and when the child feels that there is no one he can depend upon he develops feelings of insecurity. On the other

hand, there should not be overprotection and spoiling the child, coddling or taking on all its responsibilities should be avoided.

The second need is that of being loved. The child should feel not only by the words of the parents but by actions of affection that he is loved and wanted. This is particularly important when a younger child is born into the family. The child must not feel that he is shut out but he should be made to realize that he still is loved by the parents and it is advisable that he be allowed to share in the affection for the new baby. Care should be taken, however, that the child should not be over loved. "Smother-love" can have as deleterious an effect on the growth of the child's personality as can the lack of love and affection.

The third need of the child is that of freedom from fear of punishment. The child can be taught self-control and a respect for the rights of others by means other than punishment. If corporal punishment is felt to be necessary it should be reserved for emergencies. However, if the child

has been raised on a basis of love, the respect of that love is likely to be great enough that the emergency need not arise. When punishment is necessary it should be reasonable and spoiling the child should not alternate with punishment.

The fourth need of the child is a chance to learn independence and to take responsibility. In the early years of the child's life dependence is necessary but as he grows older he spontaneously shows desire for independence and for taking on some responsibility of his own. The parents should be willing to allow a gradual breaking away from their control, making sure, of course, that he does not go too far in one direction or another. If the child is not allowed to develop a sense of independence at the age when it is his right, he may enjoy the sense of dependence and may become bound to his parents. Later, in his social contacts, he will feel this dependency and will develop feelings of inferiority and inadequacy in his relationships.

The fifth need is that of tolerance on the

part of the parents. It is perfectly healthy for all children to react on certain impulses which are socially unacceptable. These impulses frequently appear in the fields of hostility toward others and in sexual behaviour. The parents need not be shocked by such manefestations, nor should they punish without reason. The wisest thing is to point out that people, though having similar feelings, do not usually express them. Certain impulses, though not acceptable in childhood, may become so in later life. This is particularly true of certain sexual manefestations which become acceptable in adults under the proper circumstances. Childhood masturbation should not cause the parents to be shocked as this manefestation occurs during some part of the life of the normal individual. In all cases of these impulses a tolerance on the part of the parents is usually more efficacious than are excited admonitions.

The sixth need is that of consistency in the attitude of the parents toward the child. An absolute consistency of attitude on the part of the parents is, of course, impossible but it should be

aimed at as far as possible. With parental inconsistency the child has difficulty in developing his own standards and measures of self-control. The result may be an inconsistency in the conscience of the individual who may swing from extreme tolerance of his own actions to bitter self-recrimination.

An attitude of consistency is also necessary for lessening the problems of childhood itself. It is impossible for the child to be happy if ne never knows what to expect. This inability to guage parental attitudes can lead to feelings of insecurity, anxiety and inferiority.

The child may also play on this inconsistency in order to gain his own wishes. He may find that certain actions on his part will bring about a change of mind by the parents. Later he finds that in the world these tricks and pretences do not work and he begins to feel frustrated and helpless and may develop hatred toward these people who do not accede to his desires.

The seventh need for the child is that of not being made to feel inferior. As the child is inferior in size and in other ways to adults there

is often a temptation on their part to tease and ridicule him. Every child has certain feelings of inferiority and inadequacy and such an attitude in adults only serves to intensify these feelings. When the child makes mistakes he should be dealt with kindly,as otherwise, if he is constantly laughed at, he will finally become afraid to make dicisions on his own.

The eighth need is that of self assurance on the part of the child. He should not be forced into undertaking any project which is beyond his capabilities. He may occasionally be asked to do so in order that his interest may be stimulated but constant striving to accomplish more than his abilities warrant will lead to a sense of frustration and lack of self-confidence. If he desires to do something which is not within his capacity to undertake, it may be occasionally advisable to let him do so in order that he may develop his sense of independence and responsibility. If he attempts this constantly, however, the parent should quietly divert his interests into fields of activity more in

accord with his degree of maturity. Parents should certainly not force their children in order that they may bask in the reflected glory of their child's accomplishments.

The ninth need is the satisfaction of wishes and desires which are compatible with reality. He should be allowed freedom but certainly only within the limits of socially approved behaviour. He should be allowed to play and get dirty without fearing the disapproval of his mother. He may be allowed to give voice to such expressions as "I hate you" directed at his parents without fear of a sound thrashing. However, activities which interfere with the welfare of others and himself should be dealt with by a constant firmness.

The tenth need is for honesty and frankness on the part of the parents. This need refers most particularly to the requirements of the child as he develops an increasing interest in the topic of sex. Questions directed at the parent can be met without embarrassment or shame and without a redundency of

flowery allegory.

The eleventh need is for a sense of accomplishment on the part of the child. The achievements of children should be measured, not by adult standards, but in terms of the childs age and his general abilities. If the child feels that he must compete with adult activities he will soon develop a sense of inadequacy. The child will develop considerably more self-confidence if he feels that what he accomplishes is of importance of itself regardless of its contrast to adult activities.

The twelfth need is for the child to develop a sense of normality. When a child indulges in certain activites he should not be made to feel that there is something fundamentally wrong with him. Real difficulties in the child's behaviour should not be met with a laisser-faire attitude and the idea that the child will outgrow them. On the other hand lesser problems should not be exaggerated as the child may come to believe that he is an unacceptable person.

In a child's problems it is unwise to stress the negative aspects of his behaviour and disregard the positive side. To stress the difficulties makes the child decide that he is a problem and hence is socially unacceptable.

The thirteenth and last need is for an understanding of the child's normal growth and development. The child should be directed toward natural goals rather than toward ones of perfection. Many children take the idea of perfection too seriously and are constantly open to frustration if they can only be satisfied with the best. If the child develops a rigid goal of perfection, repeated failures or partial successes, which are inevitable, will lead to feelings of inadequacy and inferiority. The child should be taught to feel real pleasure in each accomplishment and to foster a feeling of pleasure in looking forward to the next added achievement.

CHAPTER IV

THE STUDY

CHAPTER IV

INSECURITY AND PSYCHOSOMATIC SYMPTOMATOLOGY

(Series of 79 cases)

The purpose of this study was to investigate the part that insecurity plays in the causation of psychosomatic symptomatology. The material for the study was secured from the files of the Royal Alexandra Hospital in Edmonton (years 1944-46) and four histories were taken at the Colonel Mewburn Pavilion at the University of Alberta Hospital (year 1946). For a thorough investigation of the subject all histories should have been taken by the investigator in order that certain pertinent facts could have been discovered. Unfortunately this was not possible and therefore the material had to be drawn from the histories taken by the Medical Social Worker at the Royal Alexandra Hospital.

The histories used were not all as detailed as would be most desirable in such a study. The reasons for the paucity of material in many cases

were twofold. Firstly, as these cases were all referred to the Social Worker by medical men at the hospital only after emotional problems were considered to be a factor in the causation of the illness, it frequently occurred that the period for psychosomatic study was limited by the length of stay of the patient in the hospital. Secondly, as there was more work than one social worker could cover, in many instances only the most pertinent factors were able to be elicited from the patients. Thus only immediate problems could be investigated and a detailed study of the patient's background was often impracticable . However, it was felt that a sufficient amount of material was obtained that certain investigations could be undertaken.

As has been mentioned these histories were not part of routine hospital histories but were cases referred by medical men who, having made a thorough physical and laboratory investigation, and having been convinced that these findings were not sufficient evidence for the total cause of the illness, referred the patients for psychosomatic

study. Hence there was no control group of patients which could be used to estimate the significance of the emotional problems in illness.

It was impossible to determine personality types as such investigations require time and trained operators. Unfortunately there are few, if any, trained personnel in Edmonton. The use of such a technique as the Rorschach test would have been invaluable in investigating such patients but, as far as can be ascertained, there is only one such person trained in this technique in Alberta. Thus any knowledge of the personality types involved could only be gained through the impressions of the Social Worker. Fortunately, she was highly trained and skilled and, as her conclusions were extremely cautious, the material used is considered to have a high degree of validity.

As well, it was difficult to gain any knowledge regarding the intellectual capacities of the patients, other than that gained by superficial impressions, as the facilities for such testing were not at hand.

Only 79 histories, containing adequate material, were available; therefore statistical interpretation of the findings was not feasible. The only method which could be used for presenting the material was by ~~means of~~ searching for certain common factors of insecurity in the emotional histories of the patients and then presenting them along with certain conclusions.

In undertaking this study of the role of insecurity in psychosomatic illness a rather flexible use of the word insecurity is used. Insecurity is taken to mean any condition in which the patient feels consciously or implicitly that the integrity of his personality is threatened.

One purpose of this study has been to discover, as well, the part played by feelings of financial insecurity, as opposed to other forms of insecurity, in the causation of psychosomatic symptoms in these patients. However, as was to be expected, no clearly defined dichotomy was possible. It was found that there were certain cases in which

the financial situation was clearly the greatest factor in giving rise to emotional conflict in the patient. There were also cases in which financial insecurity played little if any part in the emotional picture. There was a third group in which a financial element entered to a greater or lesser degree and from the material available it was difficult to assess the degree to which financial insecurity, as opposed to other forms, ~~played~~ was present in forming the total emotional reaction pattern.

Out of a total of 79 cases there were 12 in which financial insecurity was felt to be the greatest emotional factor. The mixed group consisted of 15 cases and the largest group, consisting essentially of factors other than financial, was comprised of 52 cases.

In those cases, where insecurity was considered to be largely financial, it was found that the financial element was not always a direct factor. As a matter of fact the financial element was so inextricably mixed with other factors that it was

almost impossible to determine just how great a part it played of itself. However, in the 12 cases, in which insecurity was considered to be essentially financial, this element seemed to be the most predominant one either as a direct or an indirect cause.

In only one case did financial insecurity per se appear to be the sole causative agent. In this instance the patient was a young man who had experienced the situation of his family being on relief during his adolesence and early manhood but had finally acquired a position as hotel clerk. This was the only time during which he had any sense of security. While in the Tuberculosis Sanitorium he developed stomach complaints when he learned that his position had been given to a veteran during his absence.

In the other 11 cases the financial element was predominant but was frequently the indirect cause of the initial conflict which precipitated the illness. A significant finding was

in relation to the foreign born in this series. Of the 12 cases, consisting essentially of financial factors, 9 were foreign born. In those cases, essentially other than financial, 18 out of 67 were foreign born. The greatest factor in those of foreign birth appeared to be the disillusionment suffered on coming to Canada. Instead of the land of plenty, which they had anticipated, they arrived in Canada just before or during the years of depression and drought. This disillusionment, although not the greatest factor in the illness, was responsible for other emotional conflicts which were of importance. This, in several instances, led to marital discord which appears to have been the precipitating factor. This marital discord was of two types. In several cases the sense of financial insecurity led to quarrelling between the husband and wife and constant emotional tension being built up in the home. The other result was a conflict arising in the field of sex. Because of the fear of poverty, the fear of pregnancy enhanced this

insecurity. With little or no contraceptive knowledge, the sex conflict became almost unbearable.

Fear of poverty was also a large factor in people who had been on and off relief during the depression years and had found this to be an extremely humiliating situation. With the end of the war in sight and the prospect of unemployment looming large, the emotional conflict arising from this fear of poverty became a dominating factor.

One other way in which financial insecurity played its part was in the resentment and feeling of inadequacy arising in those who had been subjected to a series of misfortunes such as drouth, floods and fires. They began to feel that they were ill-fated and that there was something wrong with them when they found themselves involved in a series of disasters. Added to this was found the fear of not being able to provide for the family. This fear when occurring in a man who was proud and was concerned about the opinion of his neighbours gave rise to a considerable sense of insecurity as his pride

and self-respect were severely threatened.

In the series of cases which were considered to be of mixed financial insecurity, and factors other than financial, the two factors were so mixed that they will be dealt with under the headings which cover the third group of cases (factors other than financial).

The material which has been obtained from the files has been broken down into certain emotion-producing situations which have appeared with sufficient frequency, or are considered to be important enough, to warrant discussion. Several of these states usually occur in one history as the final psychosomatic symptomatology appeared to have developed as a result of several interacting emotionally-charged situations. These conditions could occur during any part of the patient's life but, where enough material was available, it was found that the emotional aspect of an adult situation was frequently due to situations occurring in childhood ~~and which~~ that gave the adult state its signifiance.

These insecurity-producing factors will be discussed as such. In an Appendix several fairly typical histories will be presented in order that the inter-relation of these factors may be noted.

It was recognized, of course, that any one of these factors, as such, would not of necessity result in illness in all people. In a previous chapter it has been pointed out that the production of psychosomatic symptoms is a way of behaviour. Therefore, the final picture of illness was considered to be the product of certain types of personality, which on being exposed to particular situations, reacted in a singular manner. Personality considerations, as noted in these histories, will be discussed at a later point.

The factors which have been considered to give rise to insecurity have been divided into 3 categories, Environmental, Sexual and Personality, and the various emotion-producing situations falling under these headings, will be discussed in the order of the greatest frequency (see table).

ENVIRONMENTAL FACTORS.

I. CHILDHOOD FACTORS.

		Frequency of Appearance.
A.	Overprotection in the home	14
B.	Lack of affection in the home	9
C.	Rejection by parents	8
D.	Early death of one parent	8
E.	Lack of emotional security in home	8
F.	Marital discord in the home	4
G.	Too much responsibility as child	4
H.	Death of both parents	2
I.	Hatred of one parent	1

II. ADULT FACTORS

A.	Inferiority re other people and situations	14
B.	Conflicts - Religious and Moral	5
C.	Early forced marriage	2
D.	Miscellaneous	4

SEXUAL FACTORS

A.	Fear of Pregnancy	6
B.	Masturbation	3
C.	Venereal Disease	2
D.	Excessive Sexual Drive	1

PERSONALITY FACTORS

(These do not add up to 79 as there was insufficent material in many of the cases)

A.	Egocentric personality	16
B.	Inadequate personality	14
C.	Inability to express emotions	12
D.	Inability of self and others to come up to standards	9
E.	Miscellaneous	2

ENVIRONMENTAL FACTORS.

I. CHILDHOOD FACTORS.

A. OVERPROTECTION IN THE HOME.

The most common situation in the childhood background of these patients, which appeared to be responsible for the production of feelings of insecurity, was that of over-protection of the child in the home. On the one hand, over-protection in childhood arose as a result of oversolicitude on the part of the parents for the child's welfare. Because of this, the child became overdependent on the family and, with this familial dependency, he was unable to adjust to people and situations outside the family. Thus,when he finally left home, he had lost the family support and, with no sense of security within himself, he became more and more insecure when he was forced against situations which he felt unable to handle. These people frequently had great difficulty in adjusting to marital life as they found themselves unable to accept responsibility. Illness appeared to be the only way out of a situation which was

intolerable to their sense of integrity.

On the other hand, overprotection in the home also occured in cases where the parents were extremely strict in their attitude toward the children. Such people frequently did not allow their children to play with others in the neighborhood. This attitude was extremely unfortunate in the case of the only child. There were frequently restrictions on certain activities and the subject of sex, and any related topics, was taboo. When people with such a background left home, often with feelings of considerable hostility, they found it very difficult to adjust to new social situations. They often developed great feelings of inferiority while at home realizing that their home life was different from that of other children, and they began to feel that they were socially unacceptable. This made for considerable insecurity in human relationships.

B. LACK OF AFFECTION IN THE HOME.

This situation is almost the reverse of the above. Here the child developed feelings of

insecurity within the home itself because there was lacking the natural bond of affection, in the parent-child relationships, which was necessary for proper emotional maturation. This lack of affection was found to be the result of several factors. It was recognized, of course, that there was no way of knowing whether the lack of affection on the part of the parents was a reality. However, the patients felt it to be true and reacted accordingly. Some parents appeared to find it difficult to express their affection overtly and, when the child was of an affectionate nature, he felt the lack of this demonstration of affection and, in some cases, developed a sense of insecurity in his relationships with the parents because he felt that they did not love him.

On the other hand, there were cases which showed an evidence of real lack of affection. In some instances this was due to illness in the family, with all attention being directed toward the ill person. In one case the mother developed psycho-

somatic symptoms, which were used as a weapon against her family, in order that she might get her own way. Such a situation was not likely to develop any feeling of security in the child's home relationships. These early engendered feelings of insecurity were found to be carried over into adult relationships and in many instances psychosomatic illnesses appeared to be the only solution which allowed some form of emotional security.

C. REJECTION BY PARENTS.

In some cases there appeared to have been actual rejection of the child on the part of the parents. This situation was likely to undermine the personal integrity of the child and very deep feelings of insecurity were the result. Particularly shattering was the situation in which the child felt that he, alone, of all the siblings, was unwanted and unloved. In this situation he had no one to turn to and he developed feelings of complete insecurity in personal relationships and, when he was finally faced with situations which are normally accepted by well integrated personalities, he was at a loss as to how to deal with them. This inability to adjust to

social situations caused even greater feelings of insecurity and finally when this lack of security became intolerable, illness appeared to offer the only solution. With illness, he was able to convince himself, at least partially, that he had some reason for not trying to adjust to his environment.

D. EARLY DEATH OF ONE PARENT.

The early death of one parent does not of necessity give rise to feelings of insecurity although, in the case of the only child, this can very easily occur. The final outcome of the death of one parent depends upon the relationship formed between the child and the remaining parent. In this study it was discovered that, when feelings of insecurity developed, this was because other factors had played a part. In certain cases, the child was rejected by the remaining parent. Either, the child had not been wanted in the first place, or else he was now felt to be a hinderance in any future plans of the remaining parent. Occasionally the rejection was complete and the child was placed with other relatives or was placed in an institution. In such

cases it was impossible for the child to develop any feeling of being wanted and loved. This was particularly the case when the child had been placed in an institution, although even this was a more healthy atmosphere for him than when he was being constantly handed around among relatives, who took him simply from a sense of duty rather than from any real affection.

With the death of one parent the child, occasionally, became extremely dependent on the remaining parent. In this case the parent turned to him for the affection lost with the death of the marital partner. The child thus became engulfed in this parental affection and found himself unable to adjust normally to other social contacts at a later date. This was comparable to the situation which arose in the case of the child from an atmosphere of familial overprotection.

It was found that, not only could the child become dependant on the remaining parent, but, in the event that the parent remarried, severe

emotional conflict could ensue. He now felt that he had been shut outside his parent's affections and, particularly if the step-parent was unsympathetic, deep feelings of insecurity and resentment arose.

E. LACK OF EMOTIONAL SECURITY IN THE HOME

This home situation differed somewhat from the conditions of rejection of the child and lack of affection in the parent-child relationships. Here a home situation was found in which the child developed feelings of insecurity because of an emotionally-charged home atmosphere. He was never sure of emotional relationships from day to day. At one time he could be overloved by one or both parents, the next he would find himself the object of his parents' scorn. Emotional relationships were very unhappy if there were feelings of inadequacy in his relationships with the other siblings and this was especially true when the child was the constant butt of their practical jokes. The presence of a family tragedy or disgrace some-

times caused constant emotional turmoil in the family. Thus, the child was unable to develop a sense of security and emotional growth, in order that he might be able to adequately meet social and personal situations later in his life.

Another situation which was found to occur was when tension arose in the families of certain foreign born parents, who had relatives in occupied countries during the war years. The constant home atmosphere of tension and worry reacted on the child as his emotional needs were not being met.

F. MARITAL DISCORD IN THE HOME

Discord in the relationships of the parents appeared to be a factor in creating a sense of insecurity in the child. The discord, of itself, created a sense of emotional tension in the home which when acting on an emotionally labile child, caused him to swing with the constant flux in the home atmosphere. However, what was even more difficult for the emotional adjustment of the child was his being used as a weapon by one parent against

the other. In this case the child was subjected to a deep emotional conflict when he was torn between his loyalties to each of the parents. For example, in the case of one of the patients, a little girl 8 years old, whose father was overseas, this was found to be true. The mother actually rejected her but was inconsistent at all times in her attitude toward her daughter. She constantly made remarks, detremental to the absent husband, in an attempt to turn the child against her father, as she wanted to leave him and go to the United States with an American soldier. She also used the child's illness as an excuse, saying that she was sure the girl would be much better in health if she took her to the States. With the father's return the child had a difficult time emotionally because of the conflict in her loyalties to her parents.

G. TOO MUCH RESPONSIBILITY AS A CHILD

This factor appeared to be related to certain financial considerations. In these cases the patients, as children, were given too much responsibility in the family. This usually occurred

in those families who were having a difficult time financially or who had a large family. The patients felt they were expected to do more than their share of the work entailed in the upkeep of the household. Because they felt they had more responsibility than they were able to carry, they became insecure within themselves and, as they reached the adult state, they became increasingly reluctant to accept any responsibility. It was noted that they frequently developed psychosomatic symptoms at those times when they were faced with more responsibility than they felt themselves capable of accepting.

H. DEATH OF BOTH PARENTS.

There were only two cases in which the death of both parents appeared to be a contributing factor to the patient's sense of insecurity. In one case the child's father (having married a second time) died and she was left to the step-mother and step-brother to raise. The child, when about 12 years of age, was sexually assaulted by the older step-brother and this relationship continued until the patient was about 15 years old at which time

she was rescued by the R. C. M. P.

In the other case, with the death of both parents, the patient was raised for a time by an aunt, with a strong sense of duty. With the death of the aunt, the girl was then passed around from relative to relative, never at any time receiving any affection or understanding. Finally, at the age of 15, she ran away and became a domestic. By this time, of course, the damage had been done and she had developed a considerable sense of inadequacy and insecurity in personal relationships.

I. HATRED OF ONE PARENT.

This was not a common situation in this series of cases. The insecurity arose as a result of the cruel treatment by the father of both the child and her mother. The child was consequently subjected to emotional insecurity as she was afraid of her father and entertained a deep resentment for him because of his treatment of the mother. As a result of this situation, she became very dependent upon the mother for she was the only person to whom the patient was able to turn for any understanding

and affection.

II. ADULT FACTORS.

A. INFERIORITY RE OTHER PEOPLE AND SITUATIONS.

This was found to be the most common problem but it was not always possible to discover the basic cause of these deep-rooted feelings of inferiority, which led to great insecurity in personal and social relationships. In certain cases the feelings of inferiority arose out of an inadequate education which the patient felt and was convinced that, because of this, he was inferior to many people. Not only did he feel inferior in this particular part of his personality but the feeling of insecurity spread into all other aspects of his relationships with people.

In other cases there appeared to be no particular reason for this feeling of inadequacy although one factor appeared to be of importance. In some cases the patient had come from a large

family in which case there had been no need in childhood for personal contacts other than those encountered within the home. However, when the family was left behind, the patient found himself unable to adjust to new social situations and this appeared to bring about the development of a great sense of insecurity in his person-to-person relationships. Nevertheless many other patients from large families did not present the same picture.

Another factor appeared to be the repeated failure of the patient to meet certain social situations. With this constant inability to cope with the social situations, a gradual feeling of inferiority began to grow and the patient finally felt that he was incapable of meeting any situation at all.

B. CONFLICTS -RELIGIOUS AND MORAL.

This form of conflict arose in certain patients who were or had been raised as Roman Catholics. In two cases the patients (both women) were living in common-law relationships and they were suffering guilt feelings because of this. There was also present the fear of eternal punishment for their

sins and it was felt that there was an unrecognized sense that their illness was a form of expiation for their sins. In other cases the conflict arose from the use of contraceptive measures against the teachings of the church. This too caused deep guilt feelings in the patients.

C. EARLY FORCED MARRIAGE.

This occurred in two cases in which both marriages were the result of the parents wanting to be rid of the children. In the first case the patient, when 12 year old, was forced to marry a man 36 years of age. With rejection by the parents and with no sexual knowledge, the girl had little opportunity to attain a sense of security in her new relationship. The husband was also a paranoid personality and was unreasonably jealous of her, accusing her of being crazy when she attempted to escape from the intolerable situation.

In the second case the girl was forced to marry at 15 years of age because the parents wanted to be freed from her as they blamed her birth for the mother's subsequent ill-health. The husband

attempted to kill her and she finally left him. Here too the sense of insecurity in this patient had a basis in a background of rejection and early marital trouble.

D. MISCELLANEOUS FACTORS.

Certain other miscellaneous factors were found to cause insecurity in the adult patient. In one case the death of the husband, on whom the patient had always depended and to whom she had given all her affection, left her with such a sense of loss and insecurity that she finally developed symptoms of a psychosomatic order.

Another insecurity-producing factor was the fear, in one patient, of going insane. Mental illness in the background of some people causes an unreasoning fear of mental breakdown especially when they are exposed to certain emotional conflicts.

One other fear which was found in two cases was that of having Cancer. In these cases these patients were unable to freely express this fear, which was greatly interfering with their

emotional life. Finally, when they had expressed this fear and when they had been shown that it was without reason, their psychosomatic symptoms cleared up.

SEXUAL FACTORS.

These factors have been treated separately although they are so closely integrated with certain others that separating them is almost an artificiality.

A. FEAR OF PREGNANCY.

The most common sexual factor giving rise to insecurity was the fear of pregnancy. This fear arose either because of inadequate knowledge of contraception or else religious teachings forbad the use of contraceptive measures. There appeared to be two fundamental reasons for not wanting pregnancy. The most common reason was financial. The combination of financial insecurity with sexual conflicts, arising out of a fear of pregnancy, was particularly likely to predispose to a deep sense of dissatisfaction and insecurity in the emotional life of the patient.

Another cause of the fear of pregnancy was found to be the result of an excessively painful first labor. With the pain and with other concomitant factors the horror of another pregnancy was so great that an adequate sexual life was impossible.

B. MASTURBATION.

Masturbation was, of course, part of the sexual life of many patients. However, in a few cases it was found to be the basis of much emotional conflict with fears concerning the results of this sexual activity. This was due in the main to faulty sexual knowledge and superstitious beliefs as to the consequence of this sexual manifestation. The extreme to which this fear could develop was seen in the case of a man who had Tuberculosis of the spine and who blamed this upon his excessive masturbation during the years preceding the onset of this condition.

C. VENEREAL DISEASE.

There were only two cases in which venereal disease appeared to be a factor in the development of a sense of insecurity in the patients. In one case there had actually been venereal disease several years earlier and the shame surrounding the condition had become somewhat transferred to all sexual activity.

When the patient later found himself involved in an extramarital sexual episode, the shame and fear were renewed and he developed cardiac symptoms.

In the second case there had never been any actual venereal disease but the patient was convinced that he was infected. The worry surrounding this produced considerable anxiety in the sexual sphere. This fear of venereal disease arose out of faulty knowledge of the manifestations and acquiring of venereal infection. He had also seen a man who was suffering considerable pain from a gonorrhoeal infection and he became greatly concerned with the subject.

D. EXCESSIVE SEXUAL DRIVE.

One patient was suffering from a considerable sense of guilt and insecurity because of what he considered to be his inordinate sexual drive. He was unable to adjust maritally and he became so concerned with the situation that he was almost paranoid in his jealousy of his wife and he accused her of carrying on illicit sexual relations with his best friend.

PERSONALITY FACTORS.

A. EGOCENTRIC PERSONALITY.

This type of personality was found to be the most frequently occurring type in this series of cases. People with this personality pattern found it difficult to adjust to other people and to environmental conditions. They frequently developed a martyr-like attitude and felt that though "everything happened to them" they had to "bear it all" . Some of these people appeared to enjoy their illness as it brought them more attention than they would otherwise have received. Also the egocentric person was likely to have an exaulted opinion of himself and, when circumstances arose which were the result of his own actions, he had great difficulty in accepting a situation which was contrary to his sense of his own ego.

B. INADEQUATE PERSONALITY.

Certain patients appeared to have had an inadequacy of personality from the very beginning. Even in childhood they were unable to adjust emotionally to situations. These people were constantly

dependent on others for emotional support and never appeared to develop any sense of self-reliance. Consequently, whenever their emotional supports appeared to be threatened, they were overwhelmed by a sense of insecurity as they felt unable, of themselves, to meet any situation which might arise.

C. INABILITY TO EXPRESS EMOTIONS.

From the cases in the series it was difficult to estimate whether this form of personality was the result of early training or whether it was partly innate. Certainly some of the patients appeared to have had difficulty from the beginning in expressing themselves. Whatever the cause, this mode of reaction was found to lead to a considerable sense of insecurity. With the inability to express their emotions, there appeared to be a great deal of emotional tension formed when they were faced with situations which they felt unable to meet. Because they were unable to express their emotions, their sense of inadequacy increased until, in these cases, illness appeared to be their only means of expression.

D. INABILITY OF SELF AND OTHERS TO COME UP TO THEIR STANDARDS

This was a very interesting personality factor and appeared frequently in those patients suffering from Gastro-Intestinal symptoms. People with this type of personality found it very difficult to adjust in their relationships with other people. They were constantly expecting more of themselves than their capabilities warranted and also they expected more of other people than could reasonably be expected. With such an attitude they were continually becoming disillusioned in their relationships with people and their inability to come up to their own standards produced an increasing sense of frustration and insecurity.

E. MISCELLANEOUS.

There were only two other personality factors that occurred in this study. One was a patient with a schizoid personality who, unable to adjust to his environment, began withdrawing into himself and produced psychosomatic symptoms.

~~Early~~ Schizophrenia frequently presents physical symptoms in the early stages.

The other case was that of a latent Homosexual who developed symptoms of a severe degree when his best friend was about to be married. Shortly after the psychosomatic study had been made he was again readmitted to hospital with an exacerbation of symptoms on the day of his friend's marriage.

CHAPTER V.

C O N C L U S I O N.

CHAPTER V.

CONCLUSION.

The purpose of the study of the emotional background of this series of psychosomatic cases has not been an attempt to bring forth any revolutionary theories. With the limitations in the material such an effort would have been without any basis in reality. A great many more detailed histories would be necessary if it were desired to prove or disprove, with any degree of finality, the relationship existing between certain environmental and personality factors and the production of psychosomatic symptomatology. Realizing the many inadequacies which existed, in attempting to interpret the material available, the purpose of the study was to discover, to some extent, the qualitative and quantitative importance of certain environmental and personality factors in the production of feelings of insecurity and consequent psychosomatic symptomatology.

Because the production of psychosomatic symptoms is considered to be a way of behaviour, it is felt that the emotional factors which have been

discussed are in keeping with the studies and discoveries which have been made in the background of personalities presenting comparable behaviour problems. The significant findings in the environmental aspect would appear to be twofold. In the first place, the element of financial insecurity was of relative unimportance in the production of psychosomatic symptoms in this particular series of cases. Financial considerations were of some importance in the production of emotional problems but it would appear that had the patient had security in the other aspects of his life, the financial factor would have been greatly minimized. The financial element seems to play a much more dominant role in problems such as delinquency. In the second place the part played by the emotional development in the home was found to be of greater significance than the emotional development as related to other environmental factors.

In the field of personality as far as could be judged, certain personality patterns appeared to be

of greater significance than others in the production of physical symptoms as a means of adjusting to emotion-producing situations. Unfortunately, the validity of these personality findings may be greatly questioned because of the lack of scientific investigation in this particular field of study.

Again it should be pointed out that no one of these factors alone is likely to produce illness. The production of psychosomatic symptoms is only one way in which people behave in relation to a variety of emotionally significant circumstances. There is no one set of rules which can be laid down in determining the method of reaction of any one individual. How he reacts is dependent upon the personality structure and the quality and quantity of those emotion-producing factors which appear to play an important part in the causation of his psychosomatic illness.

Because the production of psychosomatic symptoms is dependent upon the inter-relation of these factors, it is impossible to effect a cure in the patient by the removal of one factor alone.

The patient must be given insight into his condition and must be made to realize that his symptoms are the way in which he as an individual has attempted to meet the exigencies of his emotional life. Psychotherapy is an attempt at a reformulation of his sense of values in order that he may meet future emotional problems with a greater understanding of those situations. An attempt is made to have him realize that his symptoms have occurred as the result of his manner of reacting to emotional situations and that these reactions have arisen because of his lack of self-understanding.

APPENDIX

A

Case of Mr. B--.

The patient was admitted to the Royal Alexandra Hospital on November 2nd, 1945, suffering from acute anxiety, with physical symptoms including dizzy spells and general weakness, excessive perspiration and ringing in his ears. The symptoms had been much the same for about a year, but with greater severity previous to admission to hospital. He had been having attacks nearly every day, lasting from just a few minutes to several hours. The physical findings were essentially negative. Laboratory examinations included Glucose Tolerance Test, B.M.R., Urinalysis and C.B.C. He was referred for psychosomatic study.

Mr. B--., the eldest of five children, came from England to Canada with his family at nine years of age. On the way across Canada, a younger brother fell from the moving train, somewhere in Ontario, and suffered sever cuts and abrasions, with the resultant loss of one eye. For some reason, which the patient could not disclose, he was held to some degree responsible for this accident, probably because as the elder brother, he should have been taking care of the child. The family fought unseccessfully for years to obtain compensation from the railway, and the matter was

thrashed out continually at home.

The Mother was the dominating factor in the home. The Father wished peace at any price, and not having been very successful in England, he was persuaded by the wife to come to Canada where her parents had already settled. The Father felt lost and unhappy here, and was also in poor health and consequently unable to work for about a year because of a chronic appendix. They had been here for about two years when the maternal grandmother visited them, and the patient (11 years) left the trap-door to the cellar open in the kitchen and the grandmother fell down, breaking several ribs. There was a terrific fuss over his carelessness and this was aggravated by the blame already attached to him in connection with the brother's accident. He was sent home with the grandparents to look after her and do her share of the work. This was partly as punishment demanded by the irate grandmother, and partly, (he felt) because his mother never loved or wanted him, and his father was too weak to struggle against her. The impression was gained that the patient's coming birth had been the cause of the parents' marriage, and that as the marriage had not been successful, he was blamed by the mother for her subsequent unhappiness.

He continued to live with his grandparents for five years, never hearing once from his own parents though they were only a hundred miles or so apart. He was made to work 'like a slave' all the time, continuing at school but working long hours before and after. The grandfather believed in work as the cure for all ills, and did not believe in spending money, and while Ernest received pay for all the work done outside the home, he was not allowed to spend any of it but had to put it in the bank. His work varied from farm-hand to odd jobs when nothing else was available, as well as working in mills and mines. He worked down in a mine with the grandfather when he was 12 or 13, and was 'scared stiff', but was forced to keep at it until it was time to return to school. When he refused to work as instructed, the grandfather belted him with a heavy metal-buckled belt, and often drew blood.

He loved school and hated to be deprived of it. He reached Grade 10 at thirteen years, but from fourteen years on the school attendance law was not so strict, and his grandfather felt it more important for him to earn money than to continue at school. He had a great ambition to go on to University, and once hav-

ing that object, worked and saved more willingly, although he resented not being allowed to spend his earnings for clothing he badly needed, or for medical or dental care. He spoke of having such a bad toothache that he walked several miles to the nearest dentist, to be told on his arrival that his grandfather had phoned that there would be no payment for any care given - therefore the dentist would not treat him. A few years later, while still in his 'teens, he had had all his teeth extracted and had to wear dentures. This had been a constant source of resentment.

When he was 16, he finally ran away from the grandparents, after being belted one day by the grandfather for taking time off work (with the permission of his employer) to play on the school baseball team in the important game of the year. At this time he had $7,000 on hand. He went on to Lethbridge where he 'sowed some wild oats', and then became lonely and upset, and decided to go to his parents. Because he was now a man of substance, and they were more than usually hard up at the time, he was accepted by them. He got along well with his father from then on, but could not get along with his mother as she ruled the house. The next five years, from 16 to 21

were years of conflict. His parents needed more money than he could earn and he gave them, little by little, and then in larger amounts, practically all his savings, thus giving up the idea of University in order that he might meet their growing demands.

At 21 years he decided to marry. The mother stormed and threatened and raved about his ingratitude. The father advised him to marry if he really so desired and "not be a fool like he had been and wait too long and then marry a tyrant". He waited a while, buying furniture and then when he did marry, the mother refused to allow him to take any of his belongings out of the house. He felt he could not sue his own parents in order to get the things which he had bought and paid for, and which were in his own name.

His marriage was not happy. The wife appeared to be much like his mother, domineering, demanding, and always wanting more money than he could earn. He, on his part, took the passive way like his father - giving in so that he might avoid quarrels. The parents-in-law apparently didn't like him or approve of him, and thought he was a weakling.

Here we have a patient developing a sense of insecurity because of rejection by his parents and the consequent lack of love and affection. The constant tension in the home arising out of attempts at suing the railway company would be of little help, as it would be a constant reminder of his so-called guilt in not watching his younger brother. The grandmother's accident blamed on him, and the unsympathetic and at times cruel treatment of him by the grandparents gave him little opportunity to develop any security in human relationships.

With the final acceptance of the patient by his parents, and with the mother's final recriminations when he wanted to get married, it is little wonder that he was unable to adjust to his marital venture, especially when his wife is the prototype of his mother.

Case of Mrs. M--.

The patient was admitted to hospital March 17th, 1945, with swelling and pain in the left leg. She had had this condition for three years, at which time while at the station she had some luggage hit her legs, and she twisted the left leg. Following that occasion, her leg had been painfully swollen and never quite the same. She was not able to name any particular point of tenderness. The swelling returned with prolonged standing, working and kneeling, and when she twisted her leg. Fourteen days previous to admission she had twisted her leg while working in the kitchen. X-ray of the left leg showed no pathology.

Life History

The patient's father died at the age of 47 after five years of illness which began with 'sleeping-sickness'. He had taken ill, slept for a month and following that, both legs had been paralyzed. He would shake all over, with his mouth shaking so that he could not hold food or saliva. He had been in and out of hospital during the five years, but had been largely cared for at home. He had finally died of pneumonia. The patient had helped take care of him but had not been home during the final illness.

At the age of eight during her first year in school, she had developed 'migraine headaches'. At the same time, another little girl used to faint frequently and have some sort of seizures. The patient had been 'fleshy' when young, and she said no one had really believed she had been ill because she had not been thin. She said she had Tuberculosis of the bowel when she was young, but could give no details except that her mother had said this was the case.

It was not possible to discover any situation coincidental with the first real faint, which occured at the time of puberty. She described these fainting spells as always beginning with an acute headache, mostly around the temples, then numbness spread down her neck, back and arms. Then her arms and sometimes her legs would go numb, as if all the strength were drained out of them. Sometimes she was unconscious, but at other times she knew what was going on as if it were a dream, but she could do nothing about it."Everything in me just stops".

She was married at 19 to her present husband whom she described as 'too mild and easy-going'. He was frequently out of work and they were on relief during most of the doleful thirties, and consequently had

to live with the husband's father. He had always interfered between them and with the children, and as her husband could not stand up to his father, she had always had to do it. There had been no steady employment until his time of enlistment in June, 1941, and the patient had gone out to work partly to increase their income, but partly 'to get away from my father-in-law'. There was a great deal of walled-up resentment against him. The father-in-law died of Cancer in March, 1944, and she had nursed him during much of his illness, and had a 'nervous breakdown' after he died. "It was exactly a year ago", said the patient.

History of Previous Illnesses

1930 - Following marriage developed 'chronic appendicitis'.
1930 - 'Moderately inflamed appendix' removed.
1931 - Miscarriage.
1932 - (December) - 3 months pregnant - hyperemesis gravidarum and threatened abortoin. The history at this time noted epileptiform seizures but no occurrence of these during the two years following marriage.
1933 - Female child born, normal delivery and recovery. History at that time mentions two previous abortions, one at 3 months and one at 5½ months.
1937 - (January) - Male child born, normal delivery, etc.
1938 - (February) - Haemorrhoidectomy. History notes 'dull aching pains in right hip and leg, much worse in wet weather'. Patient says she faints about once every two weeks, usually brought on by excitement. Says she has had haemorrhoids for about 4 or 5 years - pain during and after bowel movements, never noticed any blood in stools.' Provisional diagnosis on history -

1). Haemorrhoids 2). Rheumatoid arthritis
3). Peritoneal adhesions. This is mentioned because the patient spoke frequently of her arthritis, and in her contact with the Family Welfare Bureau had given arthritis as the probable reason for her many falls when the "strength just drained out of her"

1939 - (February) - Male child born.

In August, 1941, she was admitted to Isolation for two days because of suspected Poliomyelitis. This was three months after her husband's enlistment and while her sister was visiting her for a holiday. A telegram had come for the sister late at night and the patient, thinking it must be word about her husband, had gone numb all over. By morning she had been 'practically paralyzed' and could not move her legs. She spoke with much emotion of the spinal tap that had been done, and the subsequent pain. She also spoke with resentment about the attitude of the sister, who had complained that her holiday was going to be ruined as usual by the patient's illness whenever she came to visit. She also spoke about the cruel, nagging, unbelieving things said by her father-in-law, who never believed she was really sick. In spite of the pain and the fact that she was 'practically paralyzed' she had gotten up in the morning after her shock, and had tried to do the housework, in order that the sister could carry on with her social

engagements, but she had been unable to do so.

In January, 1945, she had fallen and hurt her knee during one of her 'weak spells', and had been X-rayed at the hospital on February 1st, 1945. These weak spells had become more frequent and severe previous to admission, and she had worried about the effect of them on her children, particularly her oldest daughter, who had to carry most of the responsibility, and worried about her mother. She said that this girl had had 'chronic appendicitis' for two years and had tried to hide her pain because she had been afraid of upsetting her mother and causing another of her spells, but the pain had become so bad that the patient had called a doctor for the child. An appendectomy had been performed February 21st, 1945. It had been following the discharge of the girl from hospital and after she seemed safe, that the patient had again broken down.

(x) This seems typical of the patient's life. She has had a very difficult life, with too much responsibility even in childhood for the younger members of her family. She had resented this, but carried on in spite of symptoms as long as she could, and then collapsed. Her marriage did not give her the security she craved, with

unemployment and poverty, long years of humiliation on relief, a husband who could or would not take responsibility, a nagging, fault-finding father-in-law with whom they were forced to live. Many of her physical symptoms seem to have been suggested by those of others with whom she has lived, and with the increase of knowledge of these other symptoms, her own have become more variegated. While her husband has been overseas, she has made a valiant effort to build up a home. Pay and allowances, and even part of $100 which her husband sent her as a birthday gift, have been used frugally and wisely on the children and the home. Because of her present health she has made application that he be sent home. However, she is afraid of the resulting insecurity and loss of pay and allowances, possibility of further unemployment for him - and yet she feels that she can no longer bear the strain alone. She has been over-conscientious all her life, unable to refuse either work or responsibility on the conscious level, but has had too much thrust upon her, and illness seems to have been the way out.

(x) Social Service Worker's comments on this case.

Case of Mrs. H--.

Mrs. H--. was admitted to hospital December 26th, 1945, suffering from vomiting and flatulence, loss of appetite and general malaise. She had no definite pain but had a feeling of discomfort over her whole abdomen. She had suffered from the present symptoms since the third week in November, when she had what she called the 'flu', but which seemed to have been mostly loss of appetite and vomiting of food and greenish bile following meals, (particularly breakfast). She had also been exceedingly nervous following that time, without any specific admitted reason.

The physical examination (including X-rays,) showed a normal stomach and duodenum; normal gall-bladder; gastric-analysis indicated acid content low; marked enlargement of the thyroid on both sides. The patient stated that she had a 'fallen womb' for which a pessary had been prescribed, but which had not yet been fitted. She had been deeply disturbed about this because it had curtailed her activities to such an extent. If she walked even a block, there had been prolapse with resulting discomfort, anxiety and embarrassment. She found that even walking about the ward, to the b.r., etc, troubled her.

Mrs. H--'s anxieties seemed to lie in two fields - those about her physical condition which seemed to her to be the most acute, and those about her social and family situation. She was anxiously waiting to hear what was wrong with her, being sure that lack of definite information and specific treatment must mean that she had Cancer or something else sufficiently bad to necessitate keeping the information from her. She herself felt that probably the thyroid condition and the pelvic condition were probably at the root of her trouble, and that anxiety over these had caused the stomach trouble - because all her life when she had been worried or upset, it had caused her stomach trouble. She could not understand why her appetite had not returned after all that time, and felt frightened and frustrated at her lack of understanding of the whole situation.

Mrs. H--'s anxieties over her own condition also extended into the mental and emotional field. She had definite suicidal wishes which she had a hard time countering, and she was afraid to be left alone for fear she might get out and throw herself over the high-level bridge, or hang herself in the garage. She begged the

Social Worker to see that she was not sent home until she felt better, because neither she nor her husband could stand the anxiety of her emotional state. He had always been 'nervous', and she did not think he should have to bear the load of such worry over her. She felt that this desire for suicide, and the feeling that she no longer wished to live, would clear up if she knew what was wrong physically. This suicidal urge had just been since she had been ill, and she had the fear of Cancer.

Mrs. H-- was born in Manitoba, 59 years ago, her mother dying a couple of weeks after her birth. She believed that her father was killed in an accident but was not too sure of anything about him. She was brought up by an aunt, who gave her good care from a sense of duty more than from real affection, until her death when the patient was still young, and from then on she was passed from one relative to another, never feeling secure in affection, or knowing how long she was likely to remain. In those early days, she suffered considerably from 'stomach-trouble' when she was nervous and upset, particularly when she did not know whether she was really wanted in the home where she had been placed. She was apparently starved for affection

all those years. When she was 13 or 14 she went out to work as a domestic in Winnipeg, and continued at that work in various jobs, until she married when she was 20 years old. The patient never had a chance to go to school, and her inability to read and write was a constant source of humiliation to her, and also prevented her filling her time easily when she was alone at home.

The marriage had been fairly happy, she said, with a husband who was good to her, but who was very nervous. They had gone through some difficult times financially, and were not well-off at the time of admission, but he had steady work as a night watchman. They had four children, two dead - one a spina bifida (died a couple of weeks after birth), another dying later of mastoid. The two living children were married and away from home, although the daughter and son-in-law lived near enough to the parents to spend a great deal of time with them.

This daughter had been married 12 years without having any children. Her husband had been injured overseas in a motorcycle accident, but was home at that time and was training for a job in the city. He and his wife had decided to adopt a child, and the patient had stated that this upset her greatly, because she feared

that it would take their interest from her, and that they would be so tied up with the child that they would not be able to spend their time with her, and that she would be left alone too much. Their decision to adopt was made in November, and just about the same time a young American couple who had been sharing the patient's house with her had been transferred back to the U.S.A. and she had been left alone. Lonliness had welled up in her, and the old familiar feeling that she was not wanted by anyone returned, although she knew that her husband and two children were really fond of her. It was at this time that she first developed her symptoms.

(x) There has been the basic insecurity and desire for real affection, and hatred of being cared for just out of a sense of duty all her life. She now has the present fear of some incurable disease which would put her in the same position with her family now. There is also the need for her daughter's constant attention and the fear that this may be taken away by the possible adoption of a young child. She feels rather guilty about her selfishness, and is trying not to let this idea bother her, and says that she both wishes to see her husband and children, and yet does not wish to see them

because she is afraid that she just upsets them and makes them miserable when they do come.

(x) Social Service Worker's comments on this case.